

August 11, 1980

Dear Fred,

The Advanced Reunion Gateway Session for your Graduate Group is scheduled for September 20-28, 1980.

It will be a time not only to renew old friendships, but to be the first to experience the new Master Mind series. There also will be special exploration exercises just for Gateway Graduates, available only at the Institute.

The registration fee for Graduates is \$725, or \$650 if you now are an Institute Sustaining Member. This includes food and housing, plus three Master Mind cassettes to take home and use.

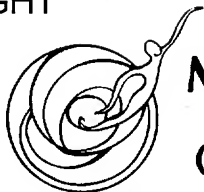
I will hold a place for you until Already reserved, so do phone or write me before then if you can come. Space is limited, and I can't promise room for you beyond that date. Please let me hear from you soon.

Love,



Alice Durrett
Gateway Coordinator

AD/gg



Monroe Institute of Applied Sciences

GATEWAY PROGRAM APPLICATION

1. NAME _____

Address _____

City _____ State _____ Zip _____

Home Phone () _____

Business Phone () _____

Present Occupation _____

Person in closest association with you: Name & Address _____

Phone () _____

Date of Birth _____

Sex _____

Married _____

Children _____

2. EDUCATION

High School _____

Graduate Work _____

College _____

Other _____

3. PHYSICAL

Height _____

Weight _____

Any chronic illness, abnormalities, disabilities _____

Major illnesses, surgical operations or accidents _____

Presently on medication _____

Special diet _____

Recent physical exam _____

For what reason _____

Do you participate in sports _____

What type _____

Exercise daily _____

General health _____

Are you right or left handed _____

4. MENTAL

Have you undergone psycho-therapy/analysis _____ . How long _____

Name and address of therapist _____

Ever hospitalized for mental breakdown or illness _____

Details _____

Do you have any special dislikes _____

Answer by number (1) Very Strong (2) Average (3) No Fear

Insects _____ Animals _____ Snakes _____ Crowds _____

Heights _____ Closeness _____ Darkness _____ Other _____

Events/things that please you most _____

5. Participation in any other mind training activities: TM, Silva, etc. _____

Present use of entertainment or psychotropic drugs such as alcohol, barbiturates, amphetamines, etc.

Drugs: _____

How often _____

What areas of personal development do you feel you need most? _____

How did you learn of Monroe Institute? _____

GATEWAY PROGRAM SESSIONS

Session	Fee	Deposit	Deposit refundable until
EXCURSION	\$ 55	\$ 15	Two weeks before the session
WEEKEND - DISCOVERY	350..	75.	Four weeks before the session
EIGHT DAY EXPLORATIONS	850.	200.	Six weeks before the session

(Fee varies with location)

I desire to participate in the following type of session _____

It is scheduled to be held at THE CENTER on Date _____

The cost to me will be \$ _____, as indicated above. I enclose a Reservation Deposit of \$ _____, as indicated above.

The balance of my Registration Fee will be paid by me on the first day of my attendance.

I understand and agree that my participation in the Gateway Program is solely for my own personal use and benefit, and that any information, experience, methods, techniques, or other data related thereto is for my own private use only.

I therefore agree that I will not release directly or indirectly any of the above through any public medium without the written approval by the Monroe Institute of Applied Sciences of the content of such public release.

Please charge my ☐ Master Charge ☐ VISA. Card No. _____ exp. date _____

Signed _____

Date _____

Send to:

MONROE INSTITUTE OF APPLIED SCIENCES

P. O. BOX 94C
FABER, VIRGINIA 22938
(804) 361-1252

PROFILE OF ADAPTATION TO LIFE

INSTRUCTIONS:

- Before answering the questions below, please read the information provided to you about the purpose of this questionnaire, protection of your right to privacy, etc.
- Try to answer each question below to the best of your ability. Do not spend too much time on any one question. Your first impulse is generally your best answer.

PLEASE COMPLETE THE FOLLOWING BACKGROUND INFORMATION:

Your Name: _____ Today's Date: _____
(Please Print) Month Day Year

- A. SEX (Check one)
(1) _____ Male
(2) _____ Female
- C. EDUCATION (Check one)
(1) _____ Less than high school
(2) _____ High school graduate
(3) _____ Some college
(4) _____ College graduate
- B. MARITAL STATUS (Check one)
(1) _____ Currently married
(2) _____ Separated, divorced, or widowed
(3) _____ Never married
- D. AGE _____

Please mark one answer for each question below.

Mark your answer like this: ☒ or ☐

	Answer Choices			
	1	2	3	4
	Never	Rarely	Some-times	Often
1. Worried about something?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Felt gloomy, blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Been on edge, tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Felt uneasy, troubled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Been unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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INSTITUTE FOR PROGRAM EVALUATION (IPEV Int'l)
Box 4654, Roanoke, Va. 24015

DURING THE PAST MONTH, I'VE . . .
(Please answer each statement below)

- Enjoyed talking with others.
- Felt trusting of people.
- Found work useful and interesting.
- Been involved, interested in things.
- Felt needed and useful.

	Answer Choices			
	1	2	3	4
	Rarely	Some-times	Often	Almost Always
6. Enjoyed talking with others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Felt trusting of people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Found work useful and interesting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Been involved, interested in things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Felt needed and useful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU LIVING WITH A SPOUSE, PARENT, OR SOMEONE IN A CLOSE RELATIONSHIP?
(1) _____ No (If you marked "no", skip the next 5 questions)
(2) _____ Yes (If you marked "yes", please answer the 5 questions below)

DURING THE PAST MONTH, HAVE YOU AND THIS PERSON (spouse, parent, etc.) . .

- Been able to talk it through when angry?
- Spent enjoyable times together?
- Discussed important matters?
- Felt close to each other?
- Agreed about social activities and friends?

	Answer Choices			
	1	2	3	4
	Rarely	Some-times	Often	Almost Always
11. Been able to talk it through when angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Spent enjoyable times together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Discussed important matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Agreed about social activities and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARE THERE CHILDREN WHERE YOU LIVE? (Mark one)
(1) _____ No (If you marked "No", skip to Question 21 on reverse side)
(2) _____ Yes (If you marked "Yes", please answer the next 5 questions)

DURING THE PAST MONTH, HAVE YOU AND THE CHILD(REN)

- Spent time talking with each other?
- Spent time doing things together?
- Treated each other with respect?
- Felt close to each other?
- Done things for each other?

	Answer Choices			
	1	2	3	4
	Rarely	Some-times	Often	Almost Always
16. Spent time talking with each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Spent time doing things together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Treated each other with respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Done things for each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please continue on reverse side

DURING THE PAST MONTH, HAVE YOU . . .

	1 Rarely	2 Some-times	3 Usually	4 Always
21. Had enough money to handle unexpected expenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Had enough money to pay your bills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Been free from worry about debts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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DURING THE LAST MONTH, HAVE YOU . .

	Answer Choices			
	1 Not Once	2 1-2 Times per MONTH	3 1-2 Times per WEEK	4 Almost Daily
24. Had headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Felt hot, feverish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Had spells of dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Waken from sleep feeling tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Had nausea (sick to stomach)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Taken medication for headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Taken medication for stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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DURING THE LAST MONTH

	Answer Choices			
	1 Not Once	2 1-2 Times per MONTH	3 1-2 Times per WEEK	4 Almost Daily
31. Have you used alcohol or non-prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you gotten high on alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Has alcohol or drugs caused problems between you & family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Has alcohol or drugs caused problems in your thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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NOTE: QUESTIONS 35-41 BELOW ASK THAT YOU INDICATE WHETHER OR NOT YOU HAVE EXPERIENCED ANY PROBLEMS IN CERTAIN AREAS OF ADJUSTMENT OR ACTIVITY DURING THE PAST MONTH. PLEASE BE SURE TO ANSWER EACH QUESTION BELOW.

DURING THE PAST MONTH, HAVE YOU HAD PROBLEMS . . .

35. With Feeling Bad (worried, unhappy, tense, etc.)?
(Mark one answer)

- (1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

36. Enjoying Other People or your Daily Life?

- (Mark one answer)
(1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

37. In the Relationship with the Person Close to You?

- (Mark one answer)
(0) ☐ I'm not in a close relationship
(1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

38. In Relating to Children in the Home?

- (0) ☐ No children where I live
(1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

39. With Having Enough Money to Handle Expenses?

- (1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

40. With Feeling Sick, or Problems with Health?

- (1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

41. In Using Too Much Alcohol or Drugs?

- (Mark one answer)
(1) ☐ No problem
(2) ☐ Some problem
(3) ☐ Serious problem

BACKGROUND INFORMATION TO PAL SCALE

From time to time, people become involved in experiences that may change their lives in certain ways. The attached scale provides information on your PROFILE OF ADAPTATION TO LIFE (PAL), and will be used only to measure the effects of our programs over time. The information you provide will remain strictly confidential and the results will be reported in group averages. You, of course, are free not to participate if that is your choice.

Please complete this background information first. Then go on and complete the PAL Scale items themselves. Your participation in this evaluation of our program is very much appreciated.

BACKGROUND INFORMATION:

Name _____ Today's Date _____ 17-22

Street _____ Phone _____

City & State _____ Zip _____

YOUR MARITAL STATUS (Check one)

- (1) _____ Currently married
 (2) _____ Separated, divorced, widowed
 (3) _____ Never married

23

SEX (Check one)

- (1) _____ Male (2) _____ Female

24

AGE _____

25-26

EDUCATION (Check one)

- (1) _____ Less than high school (3) _____ Some college
 (2) _____ High school graduate (4) _____ College graduate
 (Type of degree _____)

27

HEIGHT: _____ feet _____ inches

28-30

WEIGHT: _____ pounds

31-32

DO YOU SMOKE CIGARETTES? (Check one)

- (1) _____ Not at all (3) _____ About 1 pack per day
 (2) _____ About 1/2 pack per day (4) _____ Over 1 pack per day

33

HOW MUCH COFFEE DO YOU DRINK EACH DAY? (Check one)

- (1) _____ None or rare cup (3) _____ 3-4 cups per day
 (2) _____ About 1-2 cups per day (4) _____ 5 or more cups per day

34

DO YOU WATCH TV? (Check one)

- (1) _____ None or rarely (4) _____ 3-4 hours per day
 (2) _____ Less than 1 hour per day (5) _____ 5 or more hours per day
 (3) _____ 1-2 hours per day

35

AVERAGE HOURS OF SLEEP PER NIGHT (Check one)

- (1) _____ 4-5 hours (4) _____ 7-8 hours
 (2) _____ 5-6 hours (5) _____ 8 or more hours
 (3) _____ 6-7 hours

36

OCCUPATION OR PROFESSION: _____

37

3(80)

Prog. _____ Subj. # _____